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THE REGULATION OF PERSONAL RESTRAINT UNDER ONTARIO's CHILD AND FAMILY SERVICES ACT: A PROFESSIONAL/LEGAL PERSPECTIVE

Leonard Marvy*

INTRODUCTION

The personal restraint of one human being by another has a very different meaning depending on its context. It may be one of love, care or protection; yet it may also be one of abuse or mistreatment. The question of regulating the use of personal restraints with young people[1] receiving service under the *Child and Family Services Act, 1984*[2] is presently being confronted by the policy branch of the Ministry of Community and Social Services in anticipation of the proclamation of Part VI (Extraordinary Measures) of the *CFSA*. This part regulates, among other areas, intrusive procedures and the question of whether personal restraint should fall under the intrusive procedures definition is at issue.

A recent controversy sheds light on this issue. A Toronto group home closed down due, in large part, to a dispute with the Ministry of Community and Social Services over the use of personal restraint with young people in their care.[3] To oversimplify the issue, the Ministry was reported as saying that young people should only be restrained when there is "imminent danger", while the group home was wanting to intervene as "the child is losing rational control over his or her action." Finding the line between these two 'standards' is not easy.

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1. Rather than using child, youth or adolescent, 'young person' is used throughout this paper to refer to this entire group.

2. S.O., 1984, c. 55 as am. [hereinafter *CFSA*].

3. "Group Home to Shut Doors over Dispute with Ministry" *The* [Toronto] *Globe and Mail* (September 28, 1987) A13.

Given the legal, ethical and clinical considerations required,[4] regulating personal restraint becomes a very complex problem.

The purpose of this paper is threefold: (1) to provide a professional framework for understanding the uses of personal restraint; (2) to provide a legal framework for categorizing different circumstances of personal restraint; and (3) to to provide some integration of these frameworks as a potential background for policy development in this area.

PROFESSIONAL FRAMEWORK

Personal restraint is defined for the purposes of this paper as: the use of a service provider's body (or bodies) to immobilize the movement of a young person for some period of time. This should be distinguished from mechanical restraints. These restraints (e.g. leather straps) are generally used in hospitals[5] in particular in psychiatric emergency rooms.[6] At another extreme personal restraints are not meant to include situations where a service provider is merely holding a young person's hand. The point of personal restraint is to stop some action or behaviour by the young person through the use of personal force. Personal restraint should also be distinguished from two other means of personal control used by professionals seclusion and psychotropic medication. Seclusion and restraint, while often written about together are quite different. Seclusion is placing a young person in a locked room for a period of time.[7] Psychotropic drugs are medication prescribed and used by doctors to alter the behaviour or mood of young

4. "[E]ach milieu as a social system defines a set of ultimately unacceptable behaviours (e.g., fire setting, self-mutilation). At the limit, ethical, legal and clinical considerations require external controls." P. Soloff, "Behavioural Precipitants of Restraint in the Modern Milieu" (1978) 19(2) Comprehensive Psychiatry 179 at 183.

5. For a comprehensive legal analysis of the use of mechanical restraints see: E. Saks, "The Use of Mechanical Restraints in Psychiatric Hospitals" (1986) 95 Yale L.J. 1836.

6. S. Telintelo *et al.*, "A Study of the Use of Restraint in a Psychiatric Emergency Room", (1983) 34(2) Hospital and Community Psychiatry 164.

7. This procedure is presently regulated under ss.120–122 of the *CFSA*. See "Part VI: Extraordinary Measures Implementation Issues and Recommendations", Report of the Professional Advisory Board Steering Committee, Ontario Ministry of Community and Social Services Document, September 1986 at p.C-9,10 for distinction between 'seclusion' and 'time out'.

people.[8] As noted by Wexler[9] there is currently controversy among professionals about which one of these control techniques is least intrusive. Since the *CFSA* requires the service provider to use the least intrusive procedure first, this controversy is of some importance.

The distinction between emergency uses and programmed uses of personal restraint has been made in the literature with respect to applied behaviour analysis[10] and psychiatric uses.[11] This distinction is a critical one both from the professional framework and later during the analysis of the legal framework.

PROGRAMMED USES OF RESTRAINT

The planned use of personal restraint has different goals depending on the professional community which is attempting to use it. Some literature was found on the use of planned restraints with violent psychiatric patients, however the vast majority discovered was in the field of mental retardation. In work with mentally retarded persons planned restraint is used as an applied behaviour analysis tool to modify the inappropriate behaviours of these persons. It is used for hyperactive behaviour,[12] stereotyped behaviours,[13] aggression, self-injury and property destruction,[14] the suppression of pica[15] (ingestion of inedible objects) and generally to control "the maladaptive behaviours of men-

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8. This is regulated under s. 126 of the *CFSA*.

9. D. Wexler, "Legal Aspects of Seclusion and Restraint" in K. Tardiff, ed., *The Psychiatric Uses of Seclusion and Restraint.* (Washington: American Psychiatric Press, 1984).

10. S. Spreat & D. Lipinski, "A Survey of State Policies Regarding The Use of Restrictive/Adversive Behaviour Modification Procedures" (1986) 1(2) Behavioural Residential Treatment 145 at 150.

11. *Supra*, note 9 at 111.

12. N. Singh *et al.*, "Effects of Physical Restraint on the Behaviour of Hyperactive Mentally Retarded Persons" (1984) 89(1) American Journal of Mental Deficiency 16.

13. S. Bitgood *et al.*, "Immobilization: Effects and Side Effects on Stereotyped Behaviour in Children" (1980) 4(2) Behaviour Modification 187.

14. S. Spreat & D. Stepansky, "The Effectiveness of Contingent Restraint on Agression, Self-Injury, and Property Destruction of Institutionalized Mentally Retarded Persons" (1986) 1 Behavioural Residential Treatment 57.

15. N. Singh, & L. Bakker, "Suppression of Pica by Overcorrection and Physical Restraint: A Comparative Analysis" (1984) 14(3) Journal of Autism and Developmental Disorders 331.

tally retarded persons."[16] It should be noted however that it is "inappropriate to consider contingent restraint to be a valid, broad spectrum treatment modality for mentally retarded persons, [as there is an] inadequate number of replications across both subject types and behavioral typologies"[17] to allow one to generalize. This point is enhanced when one realizes that much of the literature examines the effects on only one or two profoundly retarded individuals.[18] One author has even shown that personal restraint, under certain conditions with certain young people can act as a reinforcer strengthening the behaviour it is supposed to be diminishing.[19]

The planned use of personal restraints with mentally retarded persons is clearly in practice. Spreat and Lipinski state that "approximately 74% (25 of 34 relevant policies) of the states appear to permit the use of mechanical or personal restraint as a treatment modality."[20] In Ontario a Ministry of Community and Social Services document provides definitions and guidelines for the use of both mechanical and manual restraints[21] with the developmentally handicapped.

Personal restraint is also used with psychiatrically disturbed young people. Soloff has noted that "Containment of violent impulses and behaviour, isolation from distressing external stimuli, and definition of disrupted ego boundaries are the therapeutic principles that underlie

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16. *Ibid.* at 340.

17. *Supra*, note 14 at 60.

18. For example, see Singh *et al*, "The Effects of Physical Restraint on Self-Injurious Behaviour" (1981) 25 Journal of Mental Deficiency and Research 207 (subject: one 16 year old profoundly retarded, blind, deaf person); R. Foxx, & D. Dufrense, "Harry: The Use of Physical Restraining as a Reinforcer, Timeout from Restraint, and Fading Restraint in Treating a Self-Injurious Man" (1984) 4(1) Analysis and Intervention in Developmental Disabilities 1 (subject: one 22 year old, severely retarded, psychotic male); P. Tomporowski, "Training an Autistic Client: The Effect of Brief Restraint on Disruptive Behaviour" (1983) 14(2) Journal of Behaviour Therapy and Experimental Psychiatry 169 (subject: 13 year old profoundly retarded girl).

19. J. Favell *et al.*, "Physical Restraint as Positive Reinforcement" (1981) 85(4) American Journal of Mental Deficiency 425.

20. *Supra*, note 10 at 146.

21. *Standards for the Use of Behaviour Training and Treatment Procedures in Settings for the Developmentally Handicapped* (Toronto: Ministry of Community and Social Services, 1987) at 81-82.

the use of personal controls as a legitimate from of treatment."[22] As no studies were found which investigated the use of personal restraints with young people (who are not mentally retarded), the literature on the use of restraints with adults must be examined. Soloff reported a study of the use of leather restraints on psychiatric wards of a military teaching hospital. In this study 3.6% of the patients required restraints and, interestingly, the leading cause of restraint was non-violent behaviours, such as violation of community or administrative limits (elopement, screaming at night, etc.) followed by 'non-specific rationales' (patient escalating, unable to control behaviour, inappropriate, etc.)[23] Soloff, in stating the purposes of seclusion and restraint describes how these procedures are used with psychotic patients:

> "The poor impulse control, regressed and bizarre behaviour of psychotic patients is a legitimate indication for seclusion and restraint. In such cases, treatment is for "destimulation", containment of psychotic impulse or control over potentially dangerous agitation. Seclusion and restraint may abort imminent physical assault. Physical controls also play a critical role in preventing decompensation and progressive psychomotor agitation independent of the threat of violence. One need only to consider the psychomotor drive of an escalating manic patient or the fecal smearing of a regressed schizophrenic to retain perspective on the use of physical controls in containing disruptive impulse."[24]

Further in a discussion of consent for treatment techniques in settings under the *CFSA* the following therapeutic technique was described:

> "Holding: As the name suggests, this is the personal restraint of a child by one or more staff members. It is used to help a child express negative emotions safely or when adult intervention is needed to protect a child or others from the child's destructive impulses."[25]

While 'holding' a young person to assist them in expressing negative emotions is a waning practice, this cite (although unsupported) suggests it may still be being used.

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22. P. Soloff, "Physical Controls: The Use of Seclusion and Restraint in Modern Psychiatric Practice", in L. Roth ed., *Clinical Treatment and Management of the Violent Person* (New York: Guilford Press, 1984) at 124

.23. *Ibid.* at 125.

24. P. Soloff, "Seclusion and Restraint" in J. Lion ed., *Assaults in Psychiatric Facilities.* (New York: Grune & Stratton, 1983) at 247.

25. J. Wilson & M. Tomlinson, *Children and the Law*, 2nd ed. (Toronto: Butterworths, 1986) at 273.

Planned uses of personal restraints are found in the literature for use with both mentally retarded young people and violent or psychotic patients. Contingent personal restraint is the procedure most commonly referred to for developmentally handicapped young persons. This procedure requires careful individual plans as the restraint is contingent upon the performance of a specified behaviour. It also implies intervention before any real life threatening behaviour occurs, as the goal is to diminish behaviour leading up to the life threatening behaviour. Further the use of personal restraints to prevent 'decompensation' and progressive psychomotor agitation suggest its use is applied, ideally, before any imminent danger. Personal restraints are therefore used by professionals in planned ways with at least two distinct groups of young people.

EMERGENCY SITUATIONS

The emergency uses of personal restraint are quite distinct from planned uses of this procedure. Emergency personal restraints are applied by service providers in response to perceived emergency situations. While the service provider will (or should) have a plan with respect to emergency situations, the plan is not for the specific young person, but for how to deal with any emergency situation. There is an expectation that young people will not require external controls, however plans exists for what to do in case of an emergency.

It is no accident that in institutions for the most difficult developmentally handicapped young people and in secure treatment settings for the most severely disturbed young people, that the other forms of external control secure isolation rooms and psychotropic drugs are readily available. These young people receive the most extensive resourcing available and may require both planned and emergency personal restraints. However, just as the vast majority of service providers have neither secure isolation rooms nor psychotropic drugs readily available (hence they do not plan for these external controls with young people in their care), so do they not have personal restraint as a viable individually, planned procedure. It is used only as a response to a critical situation.

The criteria for emergency uses of extraordinary measures in the *CFSA* provide some clue for how one might define a clinical emergency. For both emergency use of intrusive procedures and psychotropic drugs the service provider must believe on reasonable grounds that delay in the use of [the intrusive procedure or psychotropic drug] "would cause

the child or another person serious mental or personal harm."[26] Dix suggests in proposed guidelines that emergency restraint should only be permitted "when therapists determine that the subject poses a substantial threat of imminent and serious harm to others."[27] Swartz outlines the inherent difficulty in determining an emergency when he states that "whereas in a medical emergency the personal condition in question is usually objectively demonstrable, a psychiatric emergency is usually intrinsically subjective."[28]

Generally speaking, it is not difficult to determine that there is an emergency when violent, destructive or seriously harmful behaviour is occurring. That is, if a young person is in the process of seriously hurting someone (including himself or herself) there is generally no difficulty having reasonable belief that serious harm will ensue unless some personal controls are quickly brought to bear. The more difficult problem is when the prudent professional wishes to intervene *before* any harm is done. This intervention is based on the professional's knowledge of the young person's past behaviour, on observations of present behaviour, on 'intuition', etc. Swartz stated that "imminent psychotic decompensations... are recognized only by subtle clinical skills."[29] While most professionals working with young people think they have this 'subtle clinical skill' to some degree, the ability to predict dangerous behaviour is not really as straightforward as it may seem.

There is evidence to show that clinicians have difficulty in accurately predicting dangerous behaviour.[30] Dix has stated that "[s]ince clinicians' ability to make accurate clinical predictions of 'dangerousness' is not empirically established, reasonable professional restraint requires that the evidence used in making such a prediction

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26. For Psychotropic drugs see s.126(4).
For Intrusive Procedures see s.125(6)(a).

27. G. Dix, "Legal and Ethical Issues in the Treatment and Handling of Violent Behaviour". In L. Rogh ed., *Clinical Treatment of the Violent Person* (New York: Guilford Press, 1987) at 189.

28. M.S. Swartz, "What Constitutes a Psychiatric Emergency: Clinical and Legal Dimensions" (1987) 15 Bulletin Am. Acad. Psychiatry and Law 57 at 61.

29. *Ibid.*

30. For reference on this topic see B. Dickens, "Legal Issues in Medical Management of Violent and Threatening Patients" (1986) 31(8) Can. J. Psychiatry 772 at 773.

include patient conduct confirming the existence of immediate danger of violence."[31] However, while the prediction of dangerousness may be difficult, as we shall see it is not the precision of the prediction that is required in an emergency but the "exercise of the reasonable proficiency ordinarily expected of mental health professionals in the circumstances".[32]

CUSTODY SITUATION

In addition to planned and emergency uses of personal restraint there is the custody use of personal restraint. The 'custody use' of personal restraint by service providers are those applications by young offenders facilities that are necessary to follow through on their legal responsibilities. If a young person is 'caught' running away from a young offenders facility and a service provider personally restrains that young person, this action may be seen as falling in a different category than either emergency or planned. It may not be life threatening or particularly serious and would therefore not classify as an emergency situation. Further, it is not planned in the sense that the goal is not to change the young person's behaviour (in a therapeutic sense). While the service provider may have a 'plan' on how to deal with runaway attempts generally, the primary goal of personally restraining the young person is to keep them in custody, not to 'treat' or 'change' behaviours. In this sense the 'custody' use of personal restraint by service providers may be distinguished from the emergency or planned uses.

SUMMARY

This section has provided a professional framework for the use of personal restraint. Personal restraint has been defined as the application of personal, physical force by professional staff. Its purpose may be therapeutic, crisis response or custodial. It has been placed on a continuum with other physical control techniques such as seclusion and psychotropic drugs. The comparative restrictiveness of each technique

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31. *Supra*, note 27 at 190.

32. *Supra*, note 30.

has been mentioned but not determined.[33] Personal restraints have also been distinguished from mechanical restraints (e.g. leather straps) or the simple hand-holding of a young person. It has been shown that its use may generally be broken down into three situations: emergency, programmed and custody. Emergency personal restraints are used across the broad spectrum of services available to young people under the *CFSA*. While the most prevalent use of programmed personal restraint is found in the literature for mentally retarded persons, there is also some indication that it is used in a programmed way with severely disturbed or violent young persons as well. Custody uses of restraint require some legislative authority (or court order) for the service provider to keep the young person in custody.

LEGAL FRAMEWORK

Balancing the interests and rights of individuals against the security and interests of society is a difficult task. The crux of the most difficult legal problems has to do with the reconciliation of individual rights and freedoms with the viability of the community required to preserve those rights and freedoms. Bringing young people into this dilemma makes it an even more difficult one to resolve. There are times when the interests of society, parents and their children all conflict.[34] When these 'clashes' occur, young people are at a distinct disadvantage. While it is true that "minor mental patients are a politically powerless and relatively invisible group", it does not necessarily follow in Ontario (as it apparently does in the U.S.) that this is a group "who must rely primarily on the wisdom of the judiciary, as opposed to the initiative of legislators, for protection of their rights".[35] Part V (Rights of Children)[36] of the *CFSA* provides children in care in Ontario with

33. It well may be that the answer to that question is contextual. That is, in some settings the use of seclusion may be more intrusive than the use of personal restraints whereas in others it may be the other way around. For example a psythiatric crisis unit for young people may consider both psychotropic drugs and seclusion less intrusive than physical restraints, whereas a group home may consider personal restraints less intrusive than secure isolation. Further, this categorization may be therapeutically valid for the different types of young people in these settings.

34. See R. O'Boyle, "Voluntary Minor Mental Patients: A Realistic Balancing of the Competing Interests of Parent, Child and State" (1984) 37 Southwestern Law Journal 1179.

35. *Ibid.* at 1202.

36. Sections 95-107

significant rights which have been legislatively enacted. The 'therapeutic communities' in the U.S. described by one author[37] would fortunately be much less likely, if not impossible, to occur in Ontario.

To set personal restraint in a legal framework this section examines three main areas of the law and then attempts to provide some analysis. First, brief mention is made of the possible *Charter* implications that may be present with respect to the use of personal restraint by professionals. Second is an examination of the common law as it pertains to this technique. Third is a look to the statutes (the *Criminal Code*, the Ontario *Mental Health Act* and the *CFSA*) to see what legislative regulations there are to bring to bear on this topic. It should be recognized that there is truly scant case law specifically on this topic so that most of the case law relevant to personal restraint will be touching on peripheral aspects of its application.

CHARTER

The procedure of personal restraint may seem like a minor intrusion to warrant *Charter* protection, however given its nexus with procedures like seclusion and mechanical restraints (which appear to be ripe for *Charter* challenges given certain circumstances) it is important to mention the areas where a challenge may occur. Sections 7 ('security of the person'), 12 ('cruel and unusual treatment') and 15 ('equality rights') seem the most logical to be used for any challenges in the area. Three

37. See J. Swift, "The Legal Rights of Adolescents Placed in 'Therapeutic Communities' ", (1984) 5(4) Children's Legal Rights Journal 8, for some remarkable cases where young people brought actions against these places. For example, the plaintiffs in one case (*Milonas v. Williams* 691 F. 2d 931 (1982)), two boys who had run away, challenged a private school for youth with behavioural problems stating they had been subject to "cruel and unusual punishment, antitherapeutic and inhumane treatment and denial of due process of law". The court enjoined the defendant school from 1) opening, reading, monitoring or censoring the boys' mail, 2) administering polygraph examinations for any purpose, 3) placing boys in isolation rooms for any reason other than to contain a boy who is physically violent; and 4) using physical force for any purpose other than to restrain a juvenile who is either physically violent and immediately dangerous to himself or others, or physically resisting institutional rules. (at 935).

authors[38] have recently discussed *Charter* impact on the mental health field. Gordon and Verdun-Jones stated that "as yet [1986], there have been no Canadian cases establishing constitutional rights to treatment, to refuse treatment or to receive treatment in the least restrictive environment."[39] In the United States in *Parham v. J.R.*[40] the Supreme Court ruled that a parent had the right to commit their child to a mental health setting even if the child opposes the admission.

Three interesting recent, Canadian cases were found where young people had challenged service providers actions on the basis of the *Charter*. In *P.D.E. v. Minister of Social Services and R. (Intervenor)*,[41] a 15 year old with health problems (cystic fibrosis requiring him to take numerous medication for respiratory and digestive problems) and a conduct disorder, who had been in the care and custody of the Minister for 3 months shy of his entire life, refused to undergo consistent treatment and was committed to a residential treatment centre (a place of safety) under s. 55 of Nova Scotia's *Children's Services Act*.[42] The Court of Appeal upheld the trial judge by finding that the order for committal did not remove any of the appellant's rights under s. 7 or s. 12 of the *Charter*. The trial judge found that the residential centre was a "place of treatment, not punishment" that the process was not criminal nor quasi criminal in that the appellant had committed no offence and the proceedings were for his own good, and that s.12 of the *Charter* did not prohibit legislation which provides for treatment being allowed to exist. Further the trial judge stated:

> "As to s.7 of the Charter being violated, I can find nowhere in the CSA which penalizes the respondent if he refuses to submit to treatment, or any legal consequences if he fails to remain on the premises at such place of safety. He is not liable to arrest, imprisonment or punishment other than by normal disciplinary

38. E. Newman, "Charter Implications for Procedures Under the Ontario Mental Health Act (1985) 5(3) Health L. in Can. 60; M. Churgin, "The Charter of Rights and Freedoms and the Mental Health System: A Comparison of Law as Written and Law As Applied" (1987) 7(4) Health L. in Can. 100; R. Gordon & S. Verdun-Jones, "The Impact of the Canadian Charter of Rights and Freedoms upon Canadian Mental Health Law: The Dawn of a New Era or Business as Usual?" 14 Law Med. & Health Care (No. 3 & 4) 190.

39. Gordon and Verdun-Jones, *Ibid.* at 190.

40. 442 U.S. 584 (1979).

41. (1987), 6 R.F.L. (3d) 371 (N.S.C.A.)

42. S.N.S. 1976, c. 8. [am. 1978, c. 37, s.18; 1983, c. 57, s.6].

> measures as enunciated by the Center. Again, *it is the responsibility of the defence to prove that his liberty or security of the person is subject to the restraint without proper process*".[43] [emphasis added]

In another recent case[44] a society placed a young person in a locked ward without possessing legislative authority and the young person sought an order declaring that her rights under s.7 and 10 of the *Charter* had been infringed. While the judge found that there was a deprivation of the rights of the appellant (either liberty interests or alternatively she had been arbitrarily detained or imprisoned), he went on to say that "[i]t is equally true that, on the facts surrounding, such was not done in any malicious way but *in an attempt to assist and protect the applicant during a short interim period of time.*"[45] [emphasis added] It seems if the detention were ongoing that the court would have granted relief, however since the young person was no longer being detained when the court heard the case (and because of the court's limited jurisdiction) no relief was provided.

A third case involving a young person, service provider, some form of restraint and the *Charter*, is one where the young person was transferred from open custody to closed custody under the provisions of s. 24.2(9) of the *Young Offender's Act*[46] because he assaulted a fellow young offender.[47] After an information was sworn the accused argued that he had already been punished by the disciplinary board (by being sent from open to closed custody) and that he could not be punished again by virtue of s. 11(h) of the *Charter*. The court ruled that the original 'offence' was not one against public laws but was based on "a series of behavioural breaches requiring internal discipline."[48]

These three cases while not directly on point do provide some perspective on how the courts may interpret the *Charter* as it pertains to young people and personal restraint. These three cases suggest that the courts presume that service providers are acting in the young person's best interest. In *P.D.E.* the order for committal was seen as 'treatment' not a 'deprivation of liberty' even though the 15 year old was refusing it.

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43. (1986), 74 N.S.R. (2d) 351 (N.S. Fam. Ct.), at 356.

44. *Re D.L.D: D.L.D. v. Family and Children's Services of London and Middlesex* (1986), 1 R.F.L. (3d) 326 (Ont. Prov. Ct. Fam. Div.).

45. *Ibid.* at 328.

46. S.C. 1980-81-82, c. 110.

47. *R. v. S.L.* [1987] W.D.F.L. #2147 (Alta. Prov. Ct.).

While in *R. v. S.L.* the transfer to closed custody was 'internal discipline' not criminal punishment leaving the young offender open to further criminal charges. This view is consistent with the landmark U.S. case of *Youngberg v. Romeo*[49] where the U.S. Supreme Court saw professional's actions as 'presumptively valid'.

COMMON LAW

Personal restraint may be understood when viewed alongside the common law tort of battery and negligence principles of duty and standard of care. Battery "protects the interest in bodily security from deliberate interference by others."[50] A person is liable for battery if they intentionally cause a harmful or offensive contact with another person. There are five defences to battery relevant to this discussion: consent, self-defence, defence of third person, defence of property and legal authority.

While battery is usually used to deal with incidences of aggression such as kicking or hitting, it also has been used where physicians (or dentists) perform operations where no consent has been obtained (or where the treatment goes well beyond the treatment consented to). While personal restraint is certainly not analogous to a surgical operation (given, generally, the higher risks and greater benefits involved in surgery), some comparisons may be made. Just as physicians have a responsibility to disclose to their patients "the nature of a proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation",[51] so too must those service providers which have planned personal restraint as part of their treatment procedures, provide young people (and/or their parents) with this type of information.

Furthermore, just as doctors in emergency situations may provide "medical attention in order to save the life or preserve the health of the patient if it is impracticable to obtain a consent from the patient or his family",[52] so too may service providers intervene with personal restraints in emergencies to save the life or preserve the health of a young person. The duty to act in an emergency seems to be unques-

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49. 102 S.C. 2452 (1982).

50. A. Linden, *Canadian Tort Law*, 3rd. Ed. (Toronto: Butterworths, 1982) at 38.

51. *Hopp v. Lepp* [1980] 2 S.C.R. 192 at 210.

52. *Supra*, note 50 at 62 (footnote omitted).

tionable for those service providers who represent services where young people are there because of acute problems (e.g. secure treatment units, etc. where the young person is there due to serious psychiatric or emotional problems). Further for those young people who are in YOA facilities or Child Welfare facilities there is legislative authority to provide custody in the former case and protection in the latter thereby making responding to an emergency imperative. In all cases there appears to be some duty to provide care and safety to young people, however given the different levels of difficulty of young people on the one hand and resources and funding on the other hand the question of standard of care is a different matter.

The court in *Haines v. Bellissimo*[53] when discussing the duty owed to a patient (who committed suicide) by "a clinical psychologist applying a healing art in a specialized capacity in a hospital environment", saw the duty as:

> "[t]he defendants owed to him *a duty to exercise that degree of reasonable skill, care, and knowledge possessed by the average of like professionals*.... To this should be added the fundamental principle of law that governs all professionals that the psychiatrist or psychologist who makes a diagnostic mistake or error in judgment does not incur liability whatever the harm, provided he exercised reasonable care and skill and took into consideration all relevant factors in arriving at his diagnosis or judgment. Psychology and psychiatry are inexact sciences and the practice thereof should not be fettered with rules so strict as to exact an infallibility on the part of the practitioner which they could not humanly possess".[54] [emphasis added]

If one extrapolates the principles in the above statement to all professionals, it follows that the duty owed by child care workers, youth workers, mental retardation counselors, social workers, etc., when faced with an emergency situation with young people, would be to exercise a "degree of reasonable skill, care, and knowledge possessed by the average of like professionals."

The landmark U.S. Supreme Court case of *Youngberg v. Romeo*[55] was quite deferential to clinical judgment when stating a professional standard. While *Romeo* made it clear that institutionalized people have a right to be free from unreasonable bodily restraints, it said that if con-

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53. (1978), 18 O.R. (2d) 177.

54. *Ibid.* at 190-191.

55. *Supra*, note 49.

stitutional deprivation were claimed because of the use of seclusion or restraint, the decision would be examined in the following light:[56]

> "The decision, if made by a professional is presumptively valid [and] liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, a practice or standard as to demonstrate that the person responsible actually did not base the decision on such a judgment."[57]

Personal restraint using common law doctrines, may be categorized as a battery (subject to consent, emergency defences, or legal authority). The evaluation of its application would, under the common law, be judged by the negligence principles, in particular, although only in part, by duty and standard of care.

STATUTES

Criminal Code

There are at least five sections in the *Criminal Code*[58] which are relevant to this discussion. Section 215 states, in part, that:

1) Every one is under a legal duty

   (a) As a parent, foster parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen;

   (c) To provide necessaries of life to a person under his charge if that person

      (i) is unable, by reason of detention, age, illness, insanity or other cause, to withdraw himself from that charge; and,

      (ii) is unable to provide himself with necessaries of life.

It is an offence if the failure to perform these duties endangers the life of a person (to whom the duty is owed) or causes or is likely to cause permanent injury to the health of the person. (s. 215(2)) This section sets out a general duty of persons in charge of those who are unable to provide for themselves and could be seen as generally applicable as

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56. *Supra*, note 9 at 112.

57. *Supra*, note 49 at 2462.

58. R.S.C., 1985, c. C-46.

providing a statutory duty for service providers to provide the necessaries of life for young people in their care (only though with respect to 'life saving' issues). An intervention by way of personal restraint to save the life or permanent health of a young person may then be founded among other things on this statutory duty.

Sections 25, 27, 34 and 43 provides defences for possible battery or assault charges. Section 25 states, in part:

> "Every one who is required or authorized by law to do anything in the administration or enforcement of the law as a peace officer or public officer or by virtue of his office is, if he acts on reasonable and probable grounds, justified in doing what he is required or authorized to do and *in using as much force as is necessary for that purpose*". [emphasis added]

Section 27 states, in part:

> "Every one is justified *in using as much force as is reasonably necessary* to prevent the commission of an offence that would be likely to cause immediate and serious injury to the person or property of anyone". [emphasis added]

While these sections are basically aimed at police actions and most of the case law describes that, they appear to be relevant as a defence for someone using personal restraint to stop another from seriously injuring someone.

These defences do not justify trespass to the person of an inmate if guards are trying to force him to comply with an institutional directive. In *R. v. Berrie*[59] penitentiary officers attempted to shave an inmate's beard by force when he refused to obey an order to shave. The court found the inmate's rights to security of person were guaranteed by the *Canadian Bill of Rights* (this was before the *Charter*), even though he was a prisoner; and that since there was nothing authorizing this act in law, and since there was no urgency or necessity requiring the use of force, the accused were convicted.

Section 34 (self defence) states, in part:

> "Every one who is unlawfully assaulted without having provoked the assault is justified in repelling force by force if the force he uses is not intended to cause death or grievous bodily harm and is *no more than is necessary to enable him to defend himself*". [emphasis added]

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59. (1975), 24 C.C.C. (2d) 66 (B.C. Prov. Ct.).

Again the case law on this section mainly deals with situations where death has ensued, however the principle of using no more force than is necessary to repel aggression is relevant to emergency personal restraint situations when staff are assaulted by young people.

The most interesting section of the Criminal Code for this discussion is section 43. It states:

> "Every school teacher, parent or person standing in the place of a parent is justified in using force by way of correction toward a pupil or child, as the case may be, who is under his care, if the force does not exceed what is reasonable under the circumstances".

There have been two cases dealt with by the Supreme Court of Canada which consider some of the issues peripherally pertinent to personal restraints. The two cases are quite similar. In *Ogg-Moss v. The Queen*,[60] the accused, a mental retardation counselor, was charged with assault after striking a 21 year-old severely handicapped resident several times on the head with a wooden spoon after the person had spilled some milk. In *R. v. Nixon*[61] the accused was a residential counselor at a psychiatric hospital and the victim was a moderately retarded adult. In this case the accused had picked up the victim and carried her to her room (in order to get her to go to bed when she was supposed to) and in the process the victim had been bruised when she hit the door. In both these cases the counselors were exonerated at trial[62] by virtue of s. 43 of the Criminal Code, however both acquittals were overturned by the Ontario Court of Appeal and upheld by the Supreme Court.

The Supreme Court while first ruling that a mentally retarded adult is *not* a child (and therefore s. 43 cannot apply) went on to say that even if a mentally retarded adult could be considered a child that a mental retardation counselor is *not* a 'person standing in the place of a parent'. The court reviewed the cases which determine what it means

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60. [1984] 2 S.C.R. 173.

61. (1985), 14 C.C.C. (3d) 257; (1984), 54 N.R. 107. (S.C.C.).

62. "The actions taken by the accused in getting the victim to go to bed when she was supposed to was the type of correction that comes within the meaning of s.43 and had the accused done otherwise she would have been in dereliction of her duty at the time. She was justified in using force and the amount she used was completely reasonable". Headnote *R. v. Nixon* (1980), 5 W.C.B. 266 (Ont. Dist. Ct.).

to take the place of a parent and one of the main criteria included assuming *all* parental obligations including pecuniary ones. The Court referred to an American case[63] where a day care worker had claimed a right to use force with a child by virtue of her similar situation to a parent. That court insisted that the person to stand in place of the parent must take on all responsibilities including maintenance and support. Dickson J. (as he then was) went on to say:

> "The parent's power of correction arises from his assumption of all the obligations of parenthood. A person does not step into the place of a parent for purposes of assuming this power unless he also assumes all these obligations. Not only does an M.R.C. have no responsibility for the pecuniary needs of the children under this temporary care, those 'parental' responsibilities which he does exercise are exercised under the direction and supervision of the Minister and the senior professional staff designated by the regulations under the *Developmental Services Act.* He does not, by exercising these limited responsibilities become in the relevant sense, a 'person standing in the place of a parent'."[64]

In conclusion the court stated:

> "I wish to reiterate that this conclusion in no way affects the right of a person in authority to use force to protect himself or others from violent or threatening behaviour. The fact that the person behaving in this violent or threatening manner may be mentally handicapped is irrelevant to this right".[65]

The Supreme Court disposed of both of these cases in the same manner. The reasoning from *Ogg-Moss* was used to dispose of *Nixon.* However, the facts were actually somewhat different and interestingly so for our purposes. In *Ogg-Moss* the victim was struck five times on the head with a wooden spoon in direct violation of a Ministry personnel directive forbidding the striking of residents for any reason whatsoever.[66] In *Nixon* however, the counselor carried (personally restrained) the patient to her room. Here the patient was not doing what she was supposed to (*viz.*, going to bed; so the counselor took her there. One wonders about the disposition of this case had there been either no

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63. *North Carolina v. Pittard* 263 S.E. 2d 809 (N.C.C.A. 1980).

64. *Supra*, note 60 at 130.

65. *Ibid.* at 133.

66. Section 97 of the *CFSA* now prohibits the use of corporate punishment with young people in service provider's care.

personal harm (merely personal restraint had been applied) or if the person being moved had been a young person rather than an adult.

If it had been a young person being made to go to bed via personal restraint on what basis, if any, could this be justified? The Supreme Court has made it very clear that the mental retardation counsellors (and hence, it would seem, child care workers, youth workers, etc.) do not stand in the place of parents for the purposes of a s.43 defence to the use of force used to 'correct' a child. The action could not then be based on 'correcting' the young person's behaviour. While most service providers would agree that carrying a very young defiant child to bed was appropriate care and supervision, as the young person's age increased there would be less consensus on this matter. Any use of physical force by a service provider with young people must therefore be based on something other than 'correction' of a young person's behaviour. It must fit into a legal/professional framework outside of the concept of 'correction' of the young person's behaviour.

Mental Health Act

The Ontario *Mental Health Act*[67] refers to restraint in three places. Section 1(t) defines 'restrain' as "keep under control by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the personal and mental condition of the patient". The sections which provide authority for the restraint of a person are ss.9(5)(b) and 14(4). Section 9(5)(b) provides authority:

> "to detain the person who is the subject of the application in a psychiatric facility and to restrain, observe and examine him in the facility for not more than 120 hours"

once an application for assessment under s.9(1) has been signed by a physician. Section 14(4) states that "An involuntary patient may be detained, restrained, observed and examined in a psychiatric facility..." and then provides some length of time guidelines for this. While no specific cases have been found under these sections having to do with restraint, the statutory authority to retrain is clearly a part of the mental health system in Ontario. Savage and McKague comment that:

> "Restraint, whether personal or chemical, is an infringement on the liberty and security of the person. While it is hardly practicable to provide a hearing and procedural protection before retraining someone who is in the process, for example, of violently assaulting

67. R.S.O. 1980, c. 262 as amended.

> another patient, that does not obviate the necessity of employing safeguards to avoid the inappropriate or excessive use of restraint. These safeguards would include clear guidelines and probably a requirement for documentation of the need for restraint with the opportunity for a later review if the patient feels the restraint to have been unjustified."[68]

The Ontario *Mental Health Act* provides statutory authority for the use of restraints subject to the statutory criteria and whatever *Charter* requirements there might be.

The Child and Family Services Act, 1984

The enacted, but as yet unproclaimed sections 124 and 125 require Ministry approval and review team approval of intrusive procedures. Section 108 defines an intrusive procedure as "a mechanical means of controlling behaviour, an aversive stimulation technique, or any other procedure that is prescribed as an intrusive procedure". In order for a service provider to use an intrusive procedure first they will be required to apply for a Ministry approval for the general use of the intrusive procedure (s. 124). Once this approval is attained a service provider will still be required to seek a review team approval of any specific use of an intrusive procedure with a young person (s. 125). The composition and duties of a review team are stated in s. 123. Review teams have the general duty of "reviewing and approving or refusing the proposed use of intrusive procedures".

The *CFSA* is rigorous in its requirements before allowing a service provider to use an intrusive procedure. First, a service provider may only use an intrusive procedure if it is specific in the Ministry approval, subject to any conditions or limitations in that approval and with the approval in advance of the service provider's review team (s. 125(3)). Secondly, the review team may only approve if: 1) appropriate consent is provided (by the young person if they are over 16 or the parent/guardian if the young person is under 16), 2) the young person's behaviour warrants it, 3) at least one other less intrusive alternative has been unsuccessfully attempted, 4) no other less intrusive technique is practicable and 5) there are reasonable grounds to believe that the procedure will improve the young person's behaviour. (s. 125(4)).

This approval scheme by the review teams is subject to an emergency exception. The service provider, *only if already approved by the Ministry*,

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68. Savage, H. and McKague, C., *Mental Health Law in Canada* (Toronto: Butterworths, 1987) at 262.

may use an intrusive procedure in an emergency (a belief on reasonable grounds that delay in using the procedure would cause the young person or another person serious mental or personal harm), for a period not exceeding seventy-two hours without the approval of the review team (s. 125(6)). The service provider must seek their review team's approval as soon as possible after the emergency intervention.

The review teams are to be composed of at least 3 members, one of whom must be someone not employed by the service provider and approved by the Minister. This entire scheme under the *CFSA* provides significant safeguards for young people before service providers are allowed to use intrusive procedures with them. If personal restraint were included as an intrusive procedure the *CFSA* would specifically authorize its use subject to certain conditions. If, however, it is not included as an intrusive procedure, then its application will be subject to alternative forms of regulation and the common law.

SUMMARY

This section has provided a legal framework for examining the use of personal restraints with young people. First, *Charter* implications were looked at. On the one hand using the *Charter* to argue that personal restraint is a violation of the security of the person, cruel and unusual treatment or an infringement of equality rights may seem like overkill, however it is not inappropriate to set this procedure against the supreme law of the land. Any service provider who intervenes with a young person is acting under the 'colour of the province's law' and therefore must abide by the *Charter*. Immobilization of a young person's freedom of movement is, prima facie, a violation of that person's freedom. As the length of time increases the violation becomes even more onerous and the requirement to justify its use as a reasonable limit which can be "demonstrably justified in a free and democratic society" becomes even more important.

The common law was used to show that the use of personal restraint may be set within the common law tort doctrine of battery and the principles of duty and standard of care. Next, sections of the Criminal Code were introduced to clarify the defences for the use of force during one's official duties or to protect oneself or others. Also the use of force for 'corrective' purposes was explored. Lastly, we looked at the *Mental Health Act* and the *CFSA* to see what statutory provisions were available to authorize the use of personal restraints with people.

The first part of this paper has placed personal restraint in a professional framework, while the second part has attempted to provide a

legal framework for the use of personal restraint. The next section is an attempt to provide a professional-legal integration for considering the use of personal restraint.

PERSONAL RESTRAINT: A LEGAL/PROFESSIONAL INTEGRATION

Professionally there are three different uses of personal restraint. They may at times overlap and sometimes the line between them may be hard to find, however they can be represented as exclusive categories. The uses are:

(1) Programmed (or planned)
(2) Emergency
(3) Custody

Legally, personal restraints may be applied to young people, without being liable for battery, in the following ways:

(1) With consent
(2) With legal authority
(3) In self-defence
(4) In defence of a third person (or property)
(5) In performance of a duty of care (e.g. to prevent serious harm coming to the young person in one's care)

Given these three professional uses of personal restraints, how do these 'fit' into the legal framework. First any programmed or planned uses of personal restraint must be done with appropriate consent. Planned, by definition, means that the professional service provider has had the opportunity to create an individualized plan for the young person and that they think this approach will benefit the young person. Second, the emergency professional use may be thought of as corresponding to the legal defences of 'self-defence', defence of a third person (or property) and prevention of serious risk to the young person (i.e. prevention of a suicide attempt). All of these would be considered a professional emergency, yet depending on the circumstances the legal category in which they would be placed and evaluated would be different. Last, is the professional 'keep in custody' use of personal

restraint. This may correspond with either the legal authority defence or possibly with the performance of a 'duty of care' requirement.[69]

CONCLUSION

This discussion paper has examined the uses of personal restraint under the *CFSA*. First, personal restraints were examined within a professional/clinical framework. It was shown that service providers use personal restraints in three ways: in emergencies, as a planned therapeutic tool to change behaviour, and to keep a young person in custody. A legal framework was the provided. *Charter* implications were noted, the common law defences to the tort of battery were used to examine legal applications of personal restraint, as were the *Criminal Code*, *Mental Health Act*, and the *CFSA*. Finally an attempt at integrating these two frameworks was made.

69. This last question is probably the most perplexing of all. For example, a child protection worker under s. 40(6) may under certain conditions (reasonable and probable grounds to believe there would be a substantial risk to the child's health or safety) apprehend a child and bring them to a place of safety. While the legal authority exists to bring a child to a place of safety, it is unclear under what authority the staff may 'hold' a child in a 'place of safety' if the child wants to leave. For example, if the professionally perceived emergency has subsided and the fourteen-year-old (for argument's sake) tries to return to the streets, may the staff in a 'place of safety' physically restrain (detain) the young person? If so, under what authority are they continuously imposing on the liberty of the young person? However, if they let the child leave (or do everything in their power short of physically stopping them) are they not in breach of their professional duty?